

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000538	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/24/2015
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00167020.</p> <p>Complaint IN00167020 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 23, 24, 2015</p> <p>Facility number: 000538 Provider number: 155620 AIM number: 100267290</p> <p>Survey team: Connie Landman RN-TC</p> <p>Census bed type: SNF: 17 SNF/NF: 136 Residential: 43 Total: 196</p> <p>Census payor type: Medicare: 25 Medicaid: 90 Other: 81 Total: 196</p> <p>Sample: 3</p> <p>Zionsville Meadows was found to be in compliance with 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00167020.</p> <p>Quality Review 02/24/15 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE